MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08892

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 33 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sullivan Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) Sullivan Ave.

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) R (Last) Babylon

4. DATE OF DEATH: (Month) Sept. (Day) 2 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: June 29-1886

9. AGE last birthday: 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charlie P. Riley

14. MOTHER'S MAIDEN NAME: Lillian Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: William J. Babylon Sullivan Avenue Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
331X Immediate cause	(a) acute cardiac dilatation	20 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — DUE TO	(b) Cebral Hemorhage	3 days
DUE TO	(c) Arteriosclerosis	4 yrs

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Myocarditis — 2 yrs

19a. DATE OF OPERATION: -

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30, 1953 to 9-2, 1953, that I last saw the deceased alive on 9-2, 1953 and that death occurred at 8.20 A.m., from the causes and on the date stated above.

SIGNATURE Chas. R. Fouty (DEGREE OR TITLE) M.D. ADDRESS Westminster Md. DATE SIGNED 9-3-53

23. BURIAL, CREMATION & REMOVAL (Specify): Burial — DATE THEREOF Sept 4/1953 — NAME OF CEMETERY OR CREMATORY Meadow Branch Cem. — LOCATION (City, town, or county) (State) Westminster Md.

DATE REC'D BY LOCAL REG. 9/3/53 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR H. Bankard & Son, Westminster, Md. ADDRESS

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 8 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05893

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 18 00-01-4
STREET ADDRESS (If rural give location) 3025 Abell Ave

3. NAME OF DECEASED: (Type or Print) (First) ADDIE (Middle) ADELINE (Last) BASS
4. DATE OF DEATH: (Month) Sept. (Day) 7 (Year) 1953
5. SEX: Fem.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 8-28-74
9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): saleslady
10b. KIND OF BUSINESS OR INDUSTRY: business (?)
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Henry Bass
14. MOTHER'S MAIDEN NAME: Henrietta FAY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 22
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
443X
Immediate cause (a) Bronchopneumonia
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertensive cardiovascular disease
DUE TO
(c)
Interval Between Onset And Death: (a) 4 days (b) longer 11 years and

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis, simple deterioration longer than two years.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 10, 19 52, to Sept. 7, 1953, that I last saw the deceased alive on 9/5, 1953, and that death occurred at 1:30 PM 9/7/53, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Gertrud Sonnenfeld M.D. Springfield State Hospital Sykesville Md. 9/7/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9-13-53
NAME OF CEMETERY OR CREMATORY Hebrew Friendship
LOCATION (City, Town, or county) Dalto (State) Md

DATE REC'D BY LOCAL REGISTRAR Sept. 11, 1953
REGISTRAR'S SIGNATURE C. Harry Weaver
24. FUNERAL DIRECTOR Jack Levin Inc
ADDRESS 2100 Eutaw Pl

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 15 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08894

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, SYKESVILLE
LENGTH OF STAY (in this place) 23 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 00-01-4
STREET ADDRESS (If rural give location) 1309 North Charles Street

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) (Last) BLUMBERG

4. DATE OF DEATH: (Month) 9 (Day) 3 (Year) 1953

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced
8. DATE OF BIRTH: Unk -
9. AGE last birthday: 53 (?) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HERMAN BLUMBERG
14. MOTHER'S MAIDEN NAME: REBECCA BLUMBERG

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X

Immediate cause (a) TERMINAL ATTACK HYPERTENSIVE CEREBRAL ENCEPHALOPATHY WITH

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) MALIGNANT HYPERTENSION

DUE TO

(c)

Interval Between Onset And Death: ✓ ✓

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CBS...with circulatory disturbance other than cerebral arteriosclerosis with psychotic reaction, with encephalopathy

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 11, 1953 to Sept. 3, 1953, that I last saw the deceased alive on Sept. 3, 1953, and that death occurred at 7 p.m. DST, from the causes and on the date stated above.

SIGNATURE Izydor Werbner (Degree or title) M. D. Springfield State Hospital, Sykesville, Md. ADDRESS DATE SIGNED 9-3-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9-7-53
NAME OF CEMETERY OR CREMATORY Balto. National Cemetery
LOCATION (City, town, or county) Balto. Md. (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 4, 1953
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Jack Lewis, Inc. ADDRESS 2100 Eutaw Place

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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SEP 8 1953
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08895

Reg. Dist. No. 8 C

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor — LENGTH OF STAY (In this place): years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rural

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor
STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) E (Last) BUTLER
4. DATE OF DEATH: (Month) Sept (Day) 19 (Year) 1953
5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 3/1/1864
9. AGE last birthday: 90 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: By Day
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jerimiah Butler
14. MOTHER'S MAIDEN NAME: Martha Little
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs Louise Butler New Windsor Rural

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) Arteriosclerotic C-V disease — years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: James T Marsh — (Degree or title) Deputy Medical Examiner — ADDRESS: Westminster Md — DATE SIGNED: 9/19/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept 21-1953 — NAME OF CEMETERY OR CREMATORY: Western Chapel — LOCATION (City, town, or county) (State): Westminster Rural Md

DATE REC'D BY LOCAL REG.: Sept 21 — REGISTRAR'S SIGNATURE: Oscar G Bendist — 24. FUNERAL DIRECTOR: D D Hartzler & Sons — ADDRESS: New Windsor, Md

Seal

RECEIVED
SEP 22 1953
BUREAU V. S.

08896

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster Rural
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 5

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster Rural
STREET ADDRESS (If rural, give location) Route 5

3. NAME OF DECEASED (Type or Print) (First) HARVEY (Middle) McKINLEY (Last) CARR
4. DATE OF DEATH (Month) Sept. (Day) 23 (Year) 1953
5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct 23-1896
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY General farming
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jessie P. Carr
14. MOTHER'S MAIDEN NAME Cora Bloom
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. Not Known
17. INFORMANT AND ADDRESS Mrs. Harvey Carr - Westminster Md - R5

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Not determined	
260X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes Mellitus	7+ years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE James T. Marsh (Degree or title) Deputy Medical Examiner ADDRESS Westminster Md DATE SIGNED Sept 23/53

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 9-26-1953
NAME OF CEMETERY ~~OR CREMATORY~~ Pipe Creek
LOCATION (City, town, or county) (State) Carroll Co., Maryland
DATE REC'D BY LOCAL REG. 9/25/53
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR C. M. Waltz, ADDRESS Winfield, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster Rural — LENGTH OF STAY (in this place): 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Grove Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge
STREET ADDRESS (If rural give location): Main St.

3. NAME OF DECEASED: (Type or Print) (First) ANNIE (Middle) E. (Last) CAYLOR

4. DATE OF DEATH: (Month) Sept. (Day) 18 (Year) 1953

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: 9/20/1868
9. AGE last birthday: 84 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joel Wilson
14. MOTHER'S MAIDEN NAME: Matilda Stultz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Edw. Caylor, Union Bridge, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

450.1

Immediate cause (a) Gangrene (Fut)
DUE TO
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio Sclerosis
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 20, 1952, to Sept 18, 1953, that I last saw the deceased alive on Sept 17, 1953, and that death occurred at Sept 18, from the causes and on the date stated above.
SIGNATURE (Degree or title): J. H. Legg M.D. — ADDRESS: Union Bridge — DATE SIGNED: 9-18-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9/21/53 — NAME OF CEMETERY OR CREMATORY: Fatherman Cem. — LOCATION (City, town, or county): Uniontown (State): Md
DATE REC'D BY LOCAL REGISTRAR: 9/19/53 — REGISTRAR'S SIGNATURE: [illegible] — 24. FUNERAL DIRECTOR: D. D. Hartner & Sons — ADDRESS: Union Bridge, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
SEP 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) since 2-8-52
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 4
STREET ADDRESS (If rural give location) 1800 Dover St.

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) --- (Last) Crossland

4. DATE OF DEATH: (Month) Spt. (Day) 28 (Year) 1953

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 1870 ?
9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) State rds.commissioner in Pa.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Crossland
14. MOTHER'S MAIDEN NAME: Mary Elzabeth Anthony

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk. (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY No: 172-18-494
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

025X

Immediate cause (a) DUE TO Coronary occlusion — Interval Between Onset And Death: minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Syphilis — ?

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with syphilitic meningo-encephalitis — more than 1½ yrs.

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ---
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ---- m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from May 10, 1952, to Spt. 28, 1953, that I last saw the deceased alive on Spt. 28, 1953, and that death occurred at 7:35 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) Martin Gross, M.D. ADDRESS Sykesville, Md. DATE SIGNED Spt. 28, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 10-2-53 NAME OF CEMETERY OR CREMATORY Springfield Hospital LOCATION (City, town, or county) (State) Sykesville, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 30, 1953 REGISTRAR'S SIGNATURE C. Harry Weir
24. FUNERAL DIRECTOR Weer & Haight - Sykesville, Md. ADDRESS
Luther H. Haight

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) since 9/20/37
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport
STREET ADDRESS (If rural give location) 224 Walnut Street

3. NAME OF DECEASED: (Type or Print) (First) Irvin (Middle) - (Last) CROWE

4. DATE OF DEATH: (Month) Sept. (Day) 8 (Year) 19 53

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 5/12/1900

9. AGE last birthday: 53 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: ---Unk-

11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Charles C. Crowe

14. MOTHER'S MAIDEN NAME: Anna Brown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY No.: unknown

17. INFORMANT & ADDRESS: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
023 X Immediate cause	(a) Bronchopneumonia	4 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Cardiovalvular disease (syphilitic ?)	? yrs.
	DUE TO (c) Syphilis	more than 17 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	General paresis of the insane	17 yrs.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ---

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---

(CITY OR TOWN) ---

(COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. ---

INJURY OCCURED While at Work ☐ Not While At Work ☐ ---

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Sept. 8, 1953, that I last saw the deceased alive on Sept. 8, 1953, and that death occurred at 2:55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Martin Gross M.D. — ADDRESS Martin Gross, M. D. Sykesville, Maryland — DATE SIGNED 9/8/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9-11-53 — NAME OF CEMETERY OR CREMATORY Pinelawn Cemetery — LOCATION (City, town, or county) (State) Westernport Maryland

DATE REC'D BY LOCAL REGISTRAR 9-9-53 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR E. A. Beal — ADDRESS Westernport, Md.

VS. A15

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SEP 10 1...
BUREAU V. S.

Item 18 Film G158 10-19-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL, SYKESVILLE
LENGTH OF STAY (in this place) 10 y 4 m 18 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE
STREET ADDRESS (If rural, give location) 4603 Keswick Road

3. NAME OF DECEASED (Type or Print) (First) EDNA (Middle) JONES (Last) DICKS
4. DATE OF DEATH (Month) 9 (Day) 16 (Year) 1953

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH 11-27-87
9. AGE last birthday 65 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George W. Jones
14. MOTHER'S MAIDEN NAME Katherine Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

434. Immediate cause (a) Pending [illegible] Examination

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute failure of the right heart due to heart muscle degeneration

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anesthesia Involutional psychotic reaction — Years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE James T. Marsh (Degree or title) Deputy Medical Examiner ADDRESS Westminster Md DATE SIGNED Sept 17/1953

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 9/19/53
NAME OF CEMETERY OR CREMATORY Loudon Park, Cem.
LOCATION (City, town, or county) Balto. Md (State)

DATE REC'D BY LOCAL REG. September 19. 1953
REGISTRAR'S SIGNATURE R.W.
24. FUNERAL DIRECTOR John A. Moran ADDRESS 3000 E. Balto. St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 311

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) since 6/26/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montg.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 15X
STREET ADDRESS (If rural give location) 125 E. Thornapple Street

3. NAME OF DECEASED: (Type or Print) (First) Lloyd (Middle) Derr (Last) FELTON
4. DATE OF DEATH: (Month) (Day) (Year) Sept. 11, 1953 19

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Nov. 18, 1885
9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Research health officer
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Anthony K. Felton
14. MOTHER'S MAIDEN NAME: Amanda Derr

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W. 1
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT & ADDRESS: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death 12 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Degenerative cardiac disease — unknown

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome, senile deterioration — 20 months

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) ---
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ---- m.
INJURY OCCURED While at Work ☐ Not While At Work ☐ ---
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from June 26, 1953, to Sep-11-, 1953, that I last saw the deceased alive on 9-11-, 1953, and that death occurred at 8 05 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) Walther H. Sonnenfeldt M.D.
ADDRESS Sykesville, Maryland
DATE SIGNED 9/11/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 16. 53
NAME OF CEMETERY OR CREMATORY Arlington National Cem.
LOCATION (City, town, or county) (State) Arlington Va.

DATE REC'D BY LOCAL REGISTRAR 9/15/53
REGISTRAR'S SIGNATURE W W Hedrick
24. FUNERAL DIRECTOR HENRY SANDER & SONS. INC.
ADDRESS Baltimore Md.

Sam Sander

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural--Sykesville
LENGTH OF STAY in this place: 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural-- Sykesville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) ERNSTINE (Middle) (Last) FRETER

4. DATE OF DEATH: (Month) Sept. (Day) 21 (Year) 19 53

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 7-4-1864

9. AGE last birthday: 89 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Hintzman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Henry A. Freeter, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Senility

4 1/2 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) hypertensive cardiovascular disease — 15 yrs

(c) arteriosclerosis & Chr. myocarditis — 15 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1935, 19..., to 9-21, 1953, that I last saw the deceased alive on 9/21, 1953, and that death occurred at 10:30P m., from the causes and on the date stated above.

SIGNATURE: C. H. Lawson (Degree or title) M.D. ADDRESS: Liberty Road, Sykesville P.O., Maryland DATE SIGNED: 9-22-53

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 9-24-1953 — NAME OF CEMETERY ~~OR CREMATORY~~: Messiah Lutheran — LOCATION (City, town, or county) (State): Carroll Co. Maryland

DATE REC'D BY LOCAL REG.: Sept. 23-53 — REGISTRAR'S SIGNATURE: Edna M. Hoerth

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz, Winfield, Md.

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SEP 2[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. [redacted] 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emory Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Ca
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Stationed at Bainbridge
STREET ADDRESS (If rural, give location) Home adress, Finksburg, Md.

3. NAME OF DECEASED (Type or Print): (First) LLETUS (Middle) ROBERT (Last) HARRISON
4. DATE OF DEATH: (Month) Sept (Day) 8 (Year) 19[illegible]

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1-22-32
9. AGE last birthday: 21 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman 3rd class
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Carroll County
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Ralph Harrison
14. MOTHER'S MAIDEN NAME: Fearn Louise Caples

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Charles Ralph Harrison, Finksburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

8231
Immediate cause (a) Fracture - dislocation Cervical Vertebra — —

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street (CITY OR TOWN) Finksburg (COUNTY) Carroll (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) 9-8-53 10 a.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Ran off Rt 1 Automobile accident

22. *I certify that I took charge of the remains described above, held an Autopsy , Inspection ✓, Inquiry ✓ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident ✓, suicide , homicide , undetermined .*

SIGNATURE (Degree or title) [illegible], Deputy Medical Examiner — ADDRESS Westminster Md — DATE SIGNED 9/8/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept. 10/53 — NAME OF CEMETERY OR CREMATORY: Finksburg Cemetery — LOCATION (City, town, or county) (State): Finksburg, Md.

DATE REC'D BY LOCAL REG. 9-9-53 — REGISTRAR'S SIGNATURE: ~~Mary B. Eline~~ L. R. Woodward

24. FUNERAL DIRECTOR — ADDRESS: J.F. Eline & Sons, Reisterstown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Nelson (Middle) A (Last) Hitchcock

4. DATE OF DEATH: (Month) September (Day) 30, (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Dec. 4, 1872

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months | Days IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Vetenerian

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Luther Hitchcock

14. MOTHER'S MAIDEN NAME: Elizabeth Clark

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs. N.A. Hitchcock, Taneytown, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause (a) myocardial failure — Interval Between Onset And Death: instantaneous

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Senility & inanition with dementia — 13 months

DUE TO (c) Generalized arteriosclerosis — 5 years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 July, 1952, to 30 Sept., 1953, that I last saw the deceased alive on 10 Sept., 1953, and that death occurred about 8:50 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walton E. Stevens, M.D. ADDRESS Taneytown, Md DATE SIGNED 2 October 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Oct. 3, 1953

NAME OF CEMETERY OR CREMATORY Reformed Cemetery

LOCATION (City, town, or county) (State) Taneytown, Maryland

DATE REC'D BY LOCAL REGISTRAR Oct 3, 1953

REGISTRAR'S SIGNATURE Ethel M Mehring Local

24. FUNERAL DIRECTOR C.O.Fuss & Son, Taneytown, Maryland ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS. A15

1

20

3

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 191

MARGIN RESERVED FOR BINDING. Please write plainly, with unfading ink. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Finksburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Finksburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Catonsville, Md.
STREET ADDRESS (If rural give location): Rosk Haven Ave.

3. NAME OF DECEASED: (First) ROBERT (Middle) V (Last) JETT (Type or Print)

4. DATE OF DEATH: (Month) 9-14-53 (Day) (Year) 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Seperated

8. DATE OF BIRTH: 9-6-1878

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired

10b. KIND OF BUSINESS OR INDUSTRY: Timing Work

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Jett

14. MOTHER'S MAIDEN NAME: Frances Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Otis Jett, Catonsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X Immediate cause (a) Cerebral embolus — Interval Between Onset And Death: 5 days

DUE TO (b) Cerebral hemiplegia — 1 year

DUE TO (c) hypotension — 1 year

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ✓ 19b. MAJOR FINDINGS OF OPERATION: ✓ 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ✓ PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓ (CITY OR TOWN) ✓ (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from 7-1-53 19 , to 9-14-53 19 , that I last saw the deceased alive on 9-12-53 , and that death occurred at 2 A.M. , from the causes and on the date stated above.

SIGNATURE (Degree or title): James L. Jaffett M.D. ADDRESS: Reisterstown Md DATE SIGNED: 9-14-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9-16-53 — NAME OF CEMETERY OR CREMATORY: Good Shepherd — LOCATION (City, town, or county) / (State): Ellicott City, Md

DATE REC'D BY LOCAL REGISTRAR: 9-15-53 — REGISTRAR'S SIGNATURE: Chas B. Linthicum. Pro. B.E. & D. — 24. FUNERAL DIRECTOR ADDRESS: F.C. Higinbothom, Ellicott City, Md.

Dr L K Woodward mnt

VS. A15

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, SYKESVILLE
LENGTH OF STAY (in this place) 3 mo. 3 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY CARROLL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANCHESTER
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) MILTON (Middle) MUNROE (Last) KINDIG
4. DATE OF DEATH: (Month) SEPT. (Day) 27 (Year) 1953
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower
8. DATE OF BIRTH: 7-20-73
9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: HENRY KINDIG
14. MOTHER'S MAIDEN NAME: MINNIE ALICE REBERT
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: Unk.
17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause (a) PULMONARY EMBOLISM — Interval Between Onset And Death: minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (026X) DUE TO (b) myocardial hypertrophy due to arteriosclerosis — years

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CBS ASSOCIATED WITH CNS SYPHILIS, MENINGOVASCULAR WITH PSYCHOTIC REACTION — Years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 24, 1953, to Sept. 27, 1953, that I last saw the deceased alive on Sept. 27 1953, and that death occurred at 8:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gertrude M. Gross, M.D. — ADDRESS Gertrude M. Gross, M. D. Springfield State Hospital, Sykesville, Md. — DATE SIGNED 9-28-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 9-30-53 — NAME OF CEMETERY OR CREMATORY Mt Carmel — LOCATION (City, town, or county) Littlestown, Pa. (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 28, 1953 — REGISTRAR'S SIGNATURE C. Harry Weer — 24. FUNERAL DIRECTOR J. W. Little & Son — ADDRESS Littlestown, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A5

RECEIVED
OCT 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS: A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
LENGTH OF STAY (in this place) 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Colonial Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
STREET ADDRESS (If rural, give location) Colonial Ave

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) ELSIE (Last) KLEE

4. DATE OF DEATH: (Month) SEPT (Day) 24 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: 11/9, 1875

9. AGE last birthday: 77 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home-wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll Co. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Brauning

14. MOTHER'S MAIDEN NAME: Rebecca Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. V. B. Hartman, Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
194X Immediate cause	(a) CEREBRAL THROMBOSIS	1-2 MINUTES
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO ADENOCARCINOMA OF THYROID & METASTASES	1 YR
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: MAY 16, 1953

19b. MAJOR FINDINGS OF OPERATION: ADENOCARCINOMA OF THYROID & CERVICAL METASTASES

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APRIL, 1953, to SEPT, 1953, that I last saw the deceased alive on 8/24, 1953, and that death occurred at 6 00 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) William Lewis Stewart, M.D. ADDRESS 59 WEST MAIN ST WESTMINSTER MD DATE SIGNED 9/24/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Sept. 26/53

NAME OF CEMETERY ~~OR CREMATORY~~ Westminster Cemetery

LOCATION (City, town, or county) (State) Westminster, Carroll Co. Md.

DATE RECD BY LOCAL REG. 9/24/53

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS J. S. Myers Jr. Westminster, Md.

RECEIVED
SEP 28 1953
BUREAU V. S.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
LENGTH OF STAY (In this place) 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Grimes Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown
STREET ADDRESS (If rural, give location) Nicodemus Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	William	Knight	Sept	30	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	Single	April 25 1882	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired carpenter	Construction	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Washington Knight	Mary Augustus Schmiat

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Charles S Knight Reisterstown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
443X Immediate cause	(a) Cerebral Hemorrhage (Rt. Hemiplegia)	20 days
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive arterio-sclerotic C-V. Disease.	2 yrs.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	None.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None.	None.	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
None.	None			

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
None. m.		None

22. I hereby certify that I attended the deceased from 9-12, 1953, to 9-30, 1953, that I last saw the deceased alive on 9-29, 1953, and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
D.D. Caples	M.D.	Reisterstown, Md.	Oct 1 53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 3 1953	Pleasant Hill Cemetery	Owings Mills	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-1-53	Mary D. Cline.	Wm Berryman & Sons	Reisterstown Md

120

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Taneytown
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Taneytown
STREET ADDRESS (If rural give location) Route #1m

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Catherine (Last) Krug

4. DATE OF DEATH: (Month) Sept (Day) 17 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: May 5, 1889

9. AGE last birthday: 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Forney

14. MOTHER'S MAIDEN NAME: Isabelle Obler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs. Ernest Eyler, Keymar, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) adenocarcinoma of uterine fundus with generalized metastasis. DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 16 mon.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 29, 1952, to Sept. 17, 1953, that I last saw the deceased alive on Sept. 16, 1953, and that death occurred at 1 P.M. D.S.T, from the causes and on the date stated above.

SIGNATURE (Degree or title) Walton E. Stevens, M.D. ADDRESS Taneytown, Md. DATE SIGNED 18 Sept. 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Sept. 20, 1953 — NAME OF CEMETERY OR CREMATORY Reformed Cemetery — LOCATION (City, town, or county) (State) Taneytown, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 18, 1953 — REGISTRAR'S SIGNATURE Ethel M Mehring

24. FUNERAL DIRECTOR — ADDRESS C.O.Fuss & Son, Taneytown, Maryland

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 80

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
LENGTH OF STAY (In this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural, give location) Main St

3. NAME OF DECEASED (Type or Print) (First) NELLIE (Middle) E (Last) LAMBERT
4. DATE OF DEATH (Month) Sept (Day) 4 (Year) 19[illegible]

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W
8. DATE OF BIRTH March 20-1883
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Penna
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter M Cashman
14. MOTHER'S MAIDEN NAME Laura J Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY No. none
17. INFORMANT AND ADDRESS Russell Lambert, New Windsor

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Occlusion	Minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic C-V disease	Years
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE James T Marsh Deputy Medical Examiner (Degree or title) ADDRESS Westminster Md DATE SIGNED 9/4/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/7/53
NAME OF CEMETERY OR CREMATORY Winters Cemetery
LOCATION (City, town, or county) New Windsor Rural (State) Md

DATE REC'D BY LOCAL REG. Sept 5/53
REGISTRAR'S SIGNATURE Cecil G Benedict Ind Reg
24. FUNERAL DIRECTOR D D Hartler & sons New Windsor, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) since 3/26/52
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glyndon
STREET ADDRESS (If rural give location) 22 Wabash Avenue

3. NAME OF DECEASED: (Type or Print) (First) Emil (Middle) — (Last) LANG
4. DATE OF DEATH: (Month) Sept. (Day) 3 (Year) 19 53
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower
8. DATE OF BIRTH: August 25, 1866
9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): dairyman and carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Unk—
11. BIRTHPLACE (State or foreign country): Switzerland
12. CITIZEN OF WHAT COUNTRY? unknown
13. FATHER'S NAME: — Unk —
14. MOTHER'S MAIDEN NAME: Kathleen - Unk—
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: unknown
17. INFORMANT & ADDRESS: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Bronchopneumonia — 2 days
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Arteriosclerotic heart disease — more than 10 yrs.
DUE TO
(c) General arteriosclerosis — more than 10 yrs.

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis, simple deterioration — about 5 yrs.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) —
(COUNTY) —
(STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June 17, 1952, to Sept. 3, 1953, that I last saw the deceased alive on Sept. 3, 1953, and that death occurred at 2:25 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Florian Nadolski, M. D. — ADDRESS Sykesville, Maryland — DATE SIGNED 9/3/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9-5-53 — NAME OF CEMETERY OR CREMATORY Druid Ridge — LOCATION (City, town, or county) Pikesville — (State) Md

DATE REC'D BY LOCAL REGISTRAR Sept. 4, 1953 — REGISTRAR'S SIGNATURE C. Harry Elwood

24. FUNERAL DIRECTOR J.E. Elwood Sons — ADDRESS Reisterstown

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville, Maryland
LENGTH OF STAY (in this place): 6 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville 15-23-2
STREET ADDRESS (If rural give location): 2 Manakee Street

3. NAME OF DECEASED (Type or Print): (First) Nolie (Middle) Adelaide (Last) Looper

4. DATE OF DEATH: (Month) 9 (Day) 1 (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 4-23-1877

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Allen Quisenberry

14. MOTHER'S MAIDEN NAME: Julia Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No
(If Yes, give war or dates of service): ---

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) ..... Cerebral hemorrhage — Interval Between Onset And Death: 10 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ..... Generalized arteriosclerosis — 9 yrs. (?)

DUE TO

(c) Hypertension

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis

19a. DATE OF OPERATION: -----

19b. MAJOR FINDINGS OF OPERATION: -----

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): -----
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: -----
(CITY OR TOWN) -----
(COUNTY)
(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY: ----- m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? -----

22. I hereby certify that I attended the deceased from 4-15-, 19 48, to 8-31-, 19 53, that I last saw the deceased alive on 8-31- 19 53, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

SIGNATURE: M. M. Mastin, M.D.
(Degree or title)
ADDRESS: Springfield State Hospital - Sykesville, Md.
DATE SIGNED: 9-1-53

23. RURAL CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept 3-1953
NAME OF CEMETERY OR CREMATORY: Larnestown Cemetery
LOCATION (City, town, or county): Montgomery County (State): Md.

DATE REC'D BY LOCAL REGISTRAR: Sept. 2, 1953
REGISTRAR'S SIGNATURE: C. Harry Eberly

24. FUNERAL DIRECTOR: Robert A. Pumphrey #7557
ADDRESS: Via Cire. Bethesda - Md.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 UB912

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Sykesville
LENGTH OF STAY (in this place) since 11/7/50
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) 29 Denton Avenue

3. NAME OF DECEASED: (Type or Print) (First) Andrew (Middle) --- (Last) LOVE

4. DATE OF DEATH: (Month) September (Day) 3 (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower

8. DATE OF BIRTH: 1867

9. AGE Last birthday: 86 ? yrs. IF UNDER 1 YEAR Months - Days - IF UNDER 24 HRS Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George R. Love

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY No.: Unknown

17. INFORMANT & ADDRESS: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
715X Immediate cause	(a) Bronchopneumonia	2 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Bedfast due to crural ulcers	2 yrs.
DUE TO		
	(c) ---	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis — 3 yrs.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION: ---

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ---

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---

(CITY OR TOWN) --- (COUNTY) --- (STATE)

TIME OF INJURY (Month) --- (Day) --- (Year) --- (Hour) --- M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Aug. 3, 1951, to Sept. 2, 1953, that I last saw the deceased alive on Sept. 2, 1953, and that death occurred at 12:20 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Martin Gross, M. D. ADDRESS Sykesville, Md. DATE SIGNED 9/3/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF Sept. 5-1953 — NAME OF CEMETERY OR CREMATORY Morelands — LOCATION (City, town, or county) (State) Taylor Ave Md.

DATE REC'D BY LOCAL REG. 9/3/53 — REGISTRAR'S SIGNATURE A. J. Hedrick M.D.

24. FUNERAL DIRECTOR Conner & Connelly — ADDRESS Sykesville Md.

VS. A15 8-53

RELEASE MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 6 y 7 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital 15

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15 X 2
STREET ADDRESS (If rural give location) 609 Ritchie Avenue

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Elmer (Last) Matter
4. DATE OF DEATH: (Month) 9 (Day) 5 (Year) 1953

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 12-5-71
9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: mission
11. BIRTHPLACE (State or foreign country): Elizabethville, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isiah Matter
14. MOTHER'S MAIDEN NAME: Emma Forney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) not known (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 4 days.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertensive cardio-vascular disease — 10 y +
DUE TO
(c) General arteriosclerosis — 10 y +

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain syndrome with psychotic reaction associated with cerebral arteriosclerosis — 10 y +

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep 1 1950, to Sep 5, 1953, that I last saw the deceased alive on 9-5-1953, and that death occurred at 9:55 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walther H. Sonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 9/5/53

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 9/8/53 NAME OF CEMETERY OR CREMATORY Ft Lincoln LOCATION (City, town, or county) (State) Cin Geo Cty

DATE REC'D BY LOCAL REGISTRAR 9-6-53 REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Warner E. Pumphrey ADDRESS 8434 Georgia Ave Silver Spring

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Sykesville, Md.
LENGTH OF STAY (in this place) 7 yrs., 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ------ Unk. -
STREET ADDRESS (If rural give location) --------

3. NAME OF DECEASED: (Type or Print) (First) MARION (Middle) T. (Last) MONTEE

4. DATE OF DEATH: (Month) 9 (Day) 25 (Year) 1953

5. SEX: MALE — 6. COLOR OR RACE: WHITE — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE — 8. DATE OF BIRTH: 5-12-05 — 9. AGE last birthday: 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore Montee
14. MOTHER'S MAIDEN NAME: Beatrice Dever

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) -
16. SOCIAL SECURITY No.: Unk.
17. INFORMANT & ADDRESS: Records, Springfield State Hospital, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 2 wks.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) ..... — 8 yrs

DUE TO (c) Pulmonary tuberculosis — 2 years +

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psy. with syphilitic meningo-encephalitis — 8 years +

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-1- ..,1950, to 9-25- .., 1953, that I last saw the deceased alive on 9-25- ., 1953., and that death occurred at 6:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H Sonnenfeldt M.D — ADDRESS Springfield State Hospital — DATE SIGNED 9/25/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10/3/53 — NAME OF CEMETERY OR CREMATORY University Med School — LOCATION (City, town, or county) Baltimore — (State) Md

DATE REC'D BY LOCAL REGISTRAR Oct. 3, 1953 — REGISTRAR'S SIGNATURE C. Harry Weir

24. FUNERAL DIRECTOR Frances A Hemsley — ADDRESS 678 N Bridle St

RECEIVED
OCT 0 1952
BUREAU V.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll Co MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
LENGTH OF STAY (In this place) [illegible]
HOSPITAL OR INSTITUTION OR STREET ADDRESS 85 W. [illegible] St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
STREET ADDRESS (If rural, give location) 85 [illegible] St.

3. NAME OF DECEASED (Type or Print) (First) CARRIE (Middle) [illegible] (Last) MYERS

4. DATE OF DEATH (Month) [illegible] (Day) 4 (Year) 1953

5. SEX [illegible]
6. COLOR OR RACE [illegible]
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) [illegible]
8. DATE OF BIRTH [illegible]
9. AGE last birthday 73 yrs. If under 1 year: Months | Days. If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) [illegible]
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible]
14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
174x Immediate cause	(a) Intestinal Obstruction	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma uterus c̄ abdominal metastasis	2 years
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December, 1951, to Sept 9, 1953, that I last saw the deceased alive on Sept 8, 1953, and that death occurred at 2 a m., from the causes and on the date stated above.

SIGNATURE James T Marsh (Degree or title) M. D. ADDRESS Westminster Md DATE SIGNED Sept 10/53

23. BURIAL, CREMATION REMOVAL (Specify) [illegible]
DATE THEREOF [illegible] 1-53
NAME OF CEMETERY OR CREMATORY [illegible]
LOCATION (City, town, or county) (State) [illegible]

DATE REC'D BY LOCAL REG. 9/11/53
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR [illegible]
ADDRESS [illegible]

RECEIVED
FEB 11 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 115 8-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster Md RD. 4
LENGTH OF STAY (in this place) 2 Month
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glover Boarding Home 63

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
STREET ADDRESS (If rural, give location) S. Main St

3. NAME OF DECEASED: (Type or Print) (First) Chas. (Middle) Howard (Last) Myers

4. DATE OF DEATH: (Month) 9 (Day) 30 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 3-7-1873

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Labor

11. BIRTHPLACE (State or foreign country): Maryland Carroll Co.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles H Myers

14. MOTHER'S MAIDEN NAME: Martha Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) ? (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Beulah H Hoffman 7629 21st Road St. Balt 18, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Arterio Sclerosis

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1, 1952 to Sept. 29, 1953, that I last saw the deceased alive on Sept. 29, 1953, and that death occurred at 2 pm Sept. 30 from the causes and on the date stated above.

SIGNATURE J. N. Legg (DEGREE OR TITLE) M D ADDRESS Union Bridge Carroll Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF 10-2-1953 NAME OF CEMETERY OR CREMATORY Pipe Creek LOCATION (City, town, or county) Near Uniontown Carroll (State) Md

DATE RECD BY LOCAL REG. 9/30/53 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Raymond A. Wright ADDRESS Union Bridge Md

RECEIVED
1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 82

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Airy; LENGTH OF STAY (In this place): MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Carroll Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Airy; STREET ADDRESS (If rural, give location): Carroll Ave.

3. NAME OF DECEASED (Type or Print): (First) NORVELL (Middle) LESTER (Last) NORWOOD

4. DATE OF DEATH: (Month) Sept (Day) 30 (Year) 19[illegible]

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 12, 1891

9. AGE Last Birthday: 61 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bench Carpenter-

10b. KIND OF BUSINESS OR INDUSTRY: Eisinger Mill & Lumber Co.

11. BIRTHPLACE (State or foreign country): Lewisdale, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willie Norwood

14. MOTHER'S MAIDEN NAME: Eunice Brandenburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 214-03-5258

17. INFORMANT AND ADDRESS: Mrs Elizabeth Norwood, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

345 Immediate cause (a) Multiple Sclerosis — Interval Between Onset and Death: Several years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ( ), Inspection (X), Inquiry (X) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes (X), accident ( ), suicide ( ), homicide ( ), undetermined ( ).*

SIGNATURE: James T. Rhoad (Degree or title): Deputy Medical Examiner ADDRESS: Westminster, Md. DATE SIGNED: 9/30/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF: Oct. 2, 1953 NAME OF CEMETERY OR CREMATORY: Damascus LOCATION (City, town, or county) (State): Damascus, Md.

DATE REC'D BY LOCAL REG.: Oct. 1 1953 REGISTRAR'S SIGNATURE: Thos D Shipley

24. FUNERAL DIRECTOR ADDRESS: Olin L. Molesworth, Damascus, Md.

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. ....74....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY CARROLL — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md. — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 3006, Darby Street

3. NAME OF DECEASED: (Type or Print) (First) LAURA (Middle) (Last) PADGETT

4. DATE OF DEATH: (Month) Sept (Day) 19, (Year) 1953

5. SEX: fem.

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: 3-2-1879

9. AGE last birthday: 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): near Staunton, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: A.M.SMITH

14. MOTHER'S MAIDEN NAME: ELIZABETH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

491K

Immediate cause (a) Bilateral bronchopneumonia — 10 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arter.scleros. 16 years

19a. DATE OF OPERATION: none — 19b. MAJOR FINDINGS OF OPERATION: none — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) none — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15 1950., to Sept. , 19 53, that I last saw the deceased alive on Sept. 19, 19 53, and that death occurred at 11 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Celia J. Brownell M.D. Springfield St. Hosp. Sykesville Md. 9/19/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Sept 23/53 — NAME OF CEMETERY OR CREMATORY Woodlawn — LOCATION (City, town, or county) (State) Woodlawn, Md

DATE REC'D BY LOCAL REGISTRAR 9-22-53 — REGISTRAR'S SIGNATURE A.W.Hedrich dmr. — 24. FUNERAL DIRECTOR Austin E. Donovan — ADDRESS 3818 Roland Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 3 y. 6 m.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-03-2
STREET ADDRESS (If rural give location) 2005 Lemington Avenue

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Lee (Last) POOLE

4. DATE OF DEATH: (Month) 9 (Day) 5 (Year) 1953

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 1-23-1864
9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Farm worker
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Washington County Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel N. Poole
14. MOTHER'S MAIDEN NAME: Mary Ann Ridenour

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) not known (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: unknown
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Terminal pneumonia
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) arteriosclerotic and degenerative
DUE TO
(c) heart disease

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. chronic brain syndrome with psychotic reaction with senile brain disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to Sept. 5, 1953, that I last saw the deceased alive on Sept. 5, 1953, and that death occurred at 1:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walther H Sonnenfeldt M.D.
ADDRESS Sykesville Md.
DATE SIGNED 9-5-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/7/53
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) Hagerstown (State) Md

DATE REC'D BY LOCAL REGISTRAR Sept. 1, 1953
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR W. T. Norment
ADDRESS Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 10 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05921

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 4, Willard St.

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) Charles (Last) Popp
4. DATE OF DEATH: (Month) Spt. (Day) 27 (Year) 1953

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): wid.
8. DATE OF BIRTH: 5-11-82
9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Railroad brakeman
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julius C. Popp
14. MOTHER'S MAIDEN NAME: Barbara Dudich

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 7 days

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Paranoid schizophrenia — 32 years

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Spt. 1, 1947, to Spt. 27, 1953, that I last saw the deceased alive on Spt. 27, 1953, and that death occurred at 6:20 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) Martin Gross, M.D. ADDRESS Sykesville, Md. DATE SIGNED 9-27-53

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF SEPT. 30, 1953
NAME OF CEMETERY OR CREMATORY MEDOWRIDGE MEMORIAL PARK
LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND.

DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Joseph T. Ambrose Jr. 1928 Sulphur Sp. Rd. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 110326

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS: A15

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ~~Carroll~~
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md.
STREET ADDRESS (If rural give location) 3211 E. Monument Street

3. NAME OF DECEASED: (Type or Print) (First) ANNA (Middle) (Last) RACKENSPERGER

4. DATE OF DEATH: (Month) Sept. (Day) 15 (Year) 1953

5. SEX: fem.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: July 14, 1875
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick DUKE
14. MOTHER'S MAIDEN NAME: Barbara STAGMEYER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: no
17. INFORMANT & ADDRESS: Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X

Immediate cause (a) Bronchopneumonia DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 10 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis — 14 years

19a. DATE OF OPERATION: -
19b. MAJOR FINDINGS OF OPERATION: -
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE - (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -
(CITY OR TOWN) (COUNTY) (STATE) -
TIME OF INJURY (Month) (Day) (Year) (Hour) - m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from Sept. 15, 1950, 19....., that I last saw the deceased alive on Sept. 15, 1953, and that death occurred at 9:25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gerhard Sonnenfeldt M.D.
ADDRESS Springfield State Hospital, Sykesville Md.
DATE SIGNED 53.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial.
DATE THEREOF 9-19-53
NAME OF CEMETERY OR CREMATORY Mt. Carmel
LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR 9-16-53
REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Lilly & Zeiler Alo
ADDRESS 403 S. Wolfe St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

1. PLACE OF DEATH.
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LENGTH OF STAY (in this place) 13 yrs.-10 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. 00
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Rose (Middle) Edna (Last) Randle

4. DATE OF DEATH: (Month) Sept. (Day) 9 (Year) 1953

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Aug. 31, 1887
9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired). None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Rosba C. Randle
14. MOTHER'S MAIDEN NAME: Catherine Arnold

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Mrs. Wm. T. Brooks, 220 Clarendon Ave, Pikesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

470 X

Immediate cause (a) Lobar pneumonia — Interval Between Onset And Death: 1 week

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Epilepsy — 51 years

DUE TO

(c)

II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ———
19b. MAJOR FINDINGS OF OPERATION ———
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/12, 1939, to 9/9/, 1953, that I last saw the deceased alive on 9/9/, 1953, and that death occurred at 2:30 am, from the causes and on the date stated above.

SIGNATURE M. N. Martin, M.D. (Degree or title) ADDRESS Springfield State Hospital, Sykesville, Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/11/53
NAME OF CEMETERY OR CREMATORY Woodlawn Cem.
LOCATION (City, town, or county) (State) Woodlawn, Md.
DATE REC'D BY LOCAL REGISTRAR 9-10-53
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Wm. J. Pickner & Sons ADDRESS Balto, 17, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, SYKESVILLE
LENGTH OF STAY (in this place) 8 yr 11 mo 23 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
STREET ADDRESS (If rural give location) (ESSEX)

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) ADELE (Last) RICHARDSON
4. DATE OF DEATH: (Month) 9 (Day) 1 (Year) 19 53
5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 10-10-87
9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CHARLES E. RICHARDSON
14. MOTHER'S MAIDEN NAME: AUGUSTA MARSHALL
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 24 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Pernicious anaemia — years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CBS ASSOCIATED WITH CONVULSIVE DISORDER WITH PSYCHOTIC REACTION — Most of life

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 12, 1953, to Sept. 1, 19 53 that I last saw the deceased alive on Sept. 1 19 53, and that death occurred at 1.50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Irene L. Hitchman, M.D. — ADDRESS — DATE SIGNED
Irene L. Hitchman, M. D. Springfield State Hospital, Sykesville, Maryland 9-1-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept. 4 - 1953
NAME OF CEMETERY OR CREMATORY: Oak Lawn
LOCATION (City, town, or county): Eastern Ave. (State) Md.
DATE REC'D BY LOCAL REGISTRAR: 9/2/53
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR: John O'Connelly
ADDRESS: Eastern Ave. Essex, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08925

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY CARROLL — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL, SYKESVILLE

LENGTH OF STAY (in this place): 2 mo 1 da

HOSPITAL OR INSTITUTION OR STREET ADDRESS: SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND — COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BALTIMORE

STREET ADDRESS (If rural give location): 2125 East Baltimore Street

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) (Last) ST. CLAIR

4. DATE OF DEATH: (Month) 9 (Day) 4 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Unk —

8. DATE OF BIRTH: 10-9-74

9. AGE Last birthday: 78 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unk —

14. MOTHER'S MAIDEN NAME: Unk —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) PULMONARY EMBOLISM — Interval Between Onset And Death: 1 minute

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(b) OLD MYOCARDIAL INFARCTION WITH ARTERIOSCLEROSIS — years

DUE TO

(c) SEVERE NEPHROSCLEROSIS — years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: CBS...cerebral arteriosclerosis, with psychotic reaction

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3 ..., 1953, to Sept. 4..., 1953, that I last saw the deceased alive on Sept. 4, 1953, and that death occurred at 6:20 a.m. DST, from the causes and on the date stated above.

SIGNATURE (Degree or title) Irene L. Hitchman, M.D. — ADDRESS: Springfield State Hospital, Sykesville, Md. — DATE SIGNED: 9-4-53

Irene L. Hitchman, M. D.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9-8-53 — NAME OF CEMETERY OR CREMATORY: Moreland Memorial — LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REGISTRAR: Sept. 5, 1953 — REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR — ADDRESS: H. Sanders & Son - North & Broadway

VS. A15 -

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Union Bridge
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural ~~Taneytown~~ Union Bridge
STREET ADDRESS (If rural give location) Rural 1

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) H (Last) Sauble

4. DATE OF DEATH: (Month) Sept (Day) 20 (Year) 1953.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: May 21, 1872
9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Sauble
14. MOTHER'S MAIDEN NAME: Mary Geiger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Mrs. Margaret B. Cook, Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

931.0

		Interval Between Onset And Death
Immediate cause	(a) Acute Myocarditis	3 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Heat exhaustion	10 days
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) 06 (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 17, 1953, to Sept 20, 1953, that I last saw the deceased alive on Sept 20, 1953, and that death occurred at 4 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. H. Legg MD
ADDRESS Union Bridge Md
DATE SIGNED 9-22-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 22, 1953
NAME OF CEMETERY OR CREMATORY Keysville Cemetery
LOCATION (City, town, or county) (State) Keysville, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 22, 1953
REGISTRAR'S SIGNATURE Leslie L. Kepp

24. FUNERAL DIRECTOR C.O.Fuss & Son, Taneytown, Maryland
ADDRESS

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland
LENGTH OF STAY (in this place) 15yrs. - 3mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY 10-01 4
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland
STREET ADDRESS (If rural give location) 3211 Ravenwood Avenue

3. NAME OF DECEASED: (Type or Print) (First) Minnie (Middle) Annie (Last) Schafer

4. DATE OF DEATH: (Month) 9- (Day) 22- (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1-21-1886

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leonard Schafer

14. MOTHER'S MAIDEN NAME: Anna Grauling

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: Unk -

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

Immediate cause (a) Lobar Pneumonia — Interval Between Onset And Death: 1 wk.

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Chr. Myocarditis — 6 yrs

DUE TO

(c)

II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with convulsive disorder. 61 yrs.

19a. DATE OF OPERATION: ----

19b. MAJOR FINDINGS OF OPERATION ----

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ----

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----

(CITY OR TOWN) ----

(COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ---- m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 4-15- ,19 42 , to 9-22- , 19 53, that I last saw the deceased alive on 9-22- , 19 53 , and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE M.N. Mastin, M.D. (Degree or title) ADDRESS Springfield State Hospital - Sykesville, Md. DATE SIGNED 9-22-53

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

DATE THEREOF SEPT. 25, 1953

NAME OF CEMETERY OR CREMATORY CEDAR HILL

LOCATION (City, town, or county) A.A. Co. (State) MARYLAND

DATE REC'D BY LOCAL REGISTRAR 9-23-53

REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR William Cook, Inc. ADDRESS 1217 ST. PAUL ST

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) since 6/7/51
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: Balt
STATE Maryland — COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 03X-2
STREET ADDRESS (If rural give location) 7031 Gough Street

3. NAME OF DECEASED: (Type or Print) (First) Henry (Middle) J. (Last) SCHAFFER
4. DATE OF DEATH: (Month) September (Day) 16 (Year) 1953
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 11/25/89
9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: John Schaffer
14. MOTHER'S MAIDEN NAME: Anna Linpinska
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY No.: unknown
17. INFORMANT & ADDRESS: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Double bronchopneumonia ... 13 days
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) ---
DUE TO
(c) ---

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Post-traumatic psychosis, cortical atrophy. 13 yrs.

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE --- (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---
(CITY OR TOWN) ---
(COUNTY)
(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ---
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Nov. 29, 1951, to Sept. 16, 1953, that I last saw the deceased alive on Sept. 16 1953, and that death occurred at 11:20 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Martin Gross, M.D. Martin Gross, M. D. Sykesville, Maryland 9/16/53

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 9-19-53
NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.
LOCATION (City, town, or county) (State) 7225 EASTERN AVE. BA. Co., MD

DATE REC'D BY LOCAL REGISTRAR 9/18/53
REGISTRAR'S SIGNATURE A. V. Redmond M.D.
24. FUNERAL DIRECTOR Charles S. Giles
ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 24
STREET ADDRESS (If rural give location) 700 S Bouldin Street

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) John (Last) Schmaus
4. DATE OF DEATH: (Month) 9 (Day) 4 (Year) 1953

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S
8. DATE OF BIRTH: 8-5-1886
9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): odd jobs
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Schmaus
14. MOTHER'S MAIDEN NAME: Anna FUHRER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
422.1
Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 8 days
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cardio-vascular disease — not known
DUE TO
(c) Arteriosclerosis — [illegible]

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain syndrome with psychotic reaction associated with arteriosclerosis — 5 months

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 15 1953, to Sep-4, 1953, that I last saw the deceased alive on Sep-4, 1953, and that death occurred at 5.58 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Walther H. Sonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 9/4/1953

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 9-8-53.
NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.
LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. BA. CO. MD

DATE REC'D BY LOCAL REGISTRAR 9/9/53
REGISTRAR'S SIGNATURE A.W. Hedrich dmr.
24. FUNERAL DIRECTOR Charles S. Zeiler ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eureka Montgomery Co Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville Burial
STREET ADDRESS (If rural give location) Barrett

3. NAME OF DECEASED: (Type or Print) (First) ADAM (Middle) WILLIAM (Last) SMITH
4. DATE OF DEATH: (Month) Sept (Day) 6 (Year) 1953

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 5/23/1907
9. AGE last birthday: 46 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer
10b. KIND OF BUSINESS OR INDUSTRY: tenant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Philip Smith
14. MOTHER'S MAIDEN NAME: Ella Bowser

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: Unk.
17. INFORMANT & ADDRESS: Florence Smith Sykesville Md

18. MEDICAL CERTIFICATION

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) generalized bilateral broncho-pneumonia DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) cardiac failure DUE TO

(c)

Interval Between Onset And Death: 4 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. chronic alcoholism

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 4, 1953, to Sept 6, 1953, that I last saw the deceased alive on Sept 6, 1953, and that death occurred at 5 15 A.M., from the causes and on the date stated above.

SIGNATURE Bertrand R. Gau (Degree or title) M.D. ADDRESS Sykesville Md DATE SIGNED Sept. 6, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) burial
DATE THEREOF 9/8/53
NAME OF CEMETERY OR CREMATORY Methodist Cem
LOCATION (City, town, or county) Taylorsville (State) Md

DATE REC'D BY LOCAL REGISTRAR 9-7-53
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR D. P. Hartlebe & Sons ADDRESS New Windsor Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A18

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, SYKESVILLE
LENGTH OF STAY (in this place) 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
STREET ADDRESS (If rural give location) 248 South Ann Street

3. NAME OF DECEASED: (Type or Print) (First) IGNATIUS (Middle) (Last) SNIADACH
4. DATE OF DEATH: (Month) 9 (Day) 3 (Year) 1953
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: 1886
9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Labor
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: HOSPITAL

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause (a) MYOCARDIAL DEGENERATION, WITH ARTERIOSCLEROSIS

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b)

DUE TO (c)

Interval Between Onset And Death: Several years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CBS with senile brain disease with psychotic reaction

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 25, 1953 to Sept. 3, 1953, that I last saw the deceased alive on Sept. 2, 1953, and that death occurred at 6:15 a.m. DST, from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] ADDRESS Springfield State Hospital, Sykesville, Md. DATE SIGNED 9-3-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF September 7/53
NAME OF CEMETERY OR CREMATORY Holy Rosary
LOCATION (City, town, or county) Balto. County (State)
DATE REC'D BY LOCAL REGISTRAR 9/4/53
REGISTRAR'S SIGNATURE A W Hedrick
24. FUNERAL DIRECTOR John M. Weber
ADDRESS 401 S Chester St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

VS. A15-1

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
LENGTH OF STAY (in this place) Twenty
HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Uniontown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) H. (Last) STONE

4. DATE OF DEATH: (Month) Sept (Day) 20 (Year) 1953

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH:
9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months 8 Days 16 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pay Master
10b. KIND OF BUSINESS OR INDUSTRY: at Spam Post
11. BIRTHPLACE (State or foreign country): Carroll Co Md
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John W Jone
14. MOTHER'S MAIDEN NAME: Susan Fritz [redacted]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-10-2815
17. INFORMANT & ADDRESS: Lee Stone

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 443X

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage	6 days.
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Hypertensive C-V disease	years
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 7, 1953, to Sept 20 1953, that I last saw the deceased alive on Sept 19, 1953, and that death occurred at 7 P.m., from the causes and on the date stated above.

SIGNATURE James T. Marsh (DEGREE OR TITLE) M. D. ADDRESS Westminster Md DATE SIGNED 9/21/53

23. BURIAL, CREMATION REMOVAL (Specify): Bured
DATE THEREOF Sept 23-53
NAME OF CEMETERY OR CREMATORY Pipe Creek
LOCATION (City, town, or county) Near Uniontown Carroll (State) Md

DATE REC'D BY LOCAL REG. 9/21/53
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Raymond K. Wright ADDRESS Union Bridge Md.

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 9 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 2305 St. Paul St.

3. NAME OF DECEASED: (Type or Print) (First) Alice (Middle) Standiford (Last) Taylor

4. DATE OF DEATH: (Month) 9 (Day) 27 (Year) 1953

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 10-5-1867
9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Not known
14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Lula Brookhart, 11 Linden Terrace, Towson, 4, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Terminal pneumonia — Interval Between Onset And Death: 48 hr

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cerebral hemmorhage — 1 week

DUE TO C.B.S. assoc. with disturbance of metabolism

(c) growth, or nutrition with senile brain disease with psychotic reaction. — 2 yr.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-12, 1953, to 9-27, 1953, that I last saw the deceased alive on 9-26, 1953, and that death occurred at 2:30 am, from the causes and on the date stated above.

SIGNATURE M. N. Mastin M.D. (Degree or title) M. N. Mastin, M.D. ADDRESS Sykesville, Md. DATE SIGNED 9-27-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/29/53
NAME OF CEMETERY OR CREMATORY Balto. Cem.
LOCATION (City, town, or county) (State) Balto., Md.
DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Wm. J. Pickner & Sons ADDRESS Balto. 17, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 33 (1374)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Oakland Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
STREET ADDRESS (If rural, give location) Oakland Road

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Henry (Last) Teal

4. DATE OF DEATH: (Month) September (Day) 27 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 6 1862

9. AGE last birthday: 90 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer for State

10b. KIND OF BUSINESS OR INDUSTRY: State Roads

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Eliza Tyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Daniel Brothers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Failure, cardiac — Interval Between Onset And Death: 1 month

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis, generalized — Years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1953, to Sept. 27, 1953, that I last saw the deceased alive on Sept 25, 1953, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clarence E. McWilliams M.D. Reisterstown, Maryland September 27 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept. 30/53 — NAME OF CEMETERY OR CREMATORY: All-Saints — LOCATION (City, town, or county) (State): Reisterstown, Md.

DATE REC'D BY LOCAL REGISTRAR: 9-28-53 — REGISTRAR'S SIGNATURE: Mary A. Eline. C. Harry Heer mm

24. FUNERAL DIRECTOR ADDRESS: J.F. Eline & Sons, Reisterstown, Md.

VS. A15

RECEIVED
SEP 30 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

1

VS A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Carroll Co. MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster

LENGTH OF STAY (in this place) 25 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 181 W. Main St

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Carroll Co.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster

STREET ADDRESS (If rural, give location) 181 W. Main St

3. NAME OF DECEASED: (Type or Print) (First) WESLEY (Middle) HOLLOWAY (Last) WAREHIME

4. DATE OF DEATH: (Month) SEPT (Day) 3 (Year) 1953

5. SEX: M.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Jan 1. 1877

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Feed mill

11. BIRTHPLACE (State or foreign country): Carroll Co. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Warehime

14. MOTHER'S MAIDEN NAME: Sarah Riggle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: 214-01-0559

17. INFORMANT & ADDRESS: Mrs. Earl S. Bowman, W. Main St Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

177X

Immediate cause (a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 2-3 DAYS

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) CARCINOMA OF PROSTATE — 1½ YRS

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from MAY, 1953, to SEPT 3, 1953, that I last saw the deceased alive on SEPT 4, 1953, and that death occurred at 2 A.M., from the causes and on the date stated above.

SIGNATURE William Lewis, Jr. (DEGREE OR TITLE) ADDRESS 59 WESTMORELAND ST WESTMINSTER, MD. DATE SIGNED 9/3/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Sept. 6. 53

NAME OF CEMETERY OR CREMATORY Kridgers Cemetery

LOCATION (City, town, or county) (State) Rural, Westminster Md.

DATE REC'D BY LOCAL REG. 9/4/53

REGISTRAR'S SIGNATURE L. Crowder

24. FUNERAL DIRECTOR J. E. Myers, Jr. ADDRESS Westminster, Md.

EIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) since 3/6/12
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) --- Unk -

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) - (Last) WENZEL

4. DATE OF DEATH: (Month) September (Day) 4 (Year) 1953

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: unknown
9. AGE last birthday: 85 ? yrs. IF UNDER 1 YEAR Months - Days - IF UNDER 24 HRS Hours - Min. -

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: --- None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY No.: unknown
17. INFORMANT & ADDRESS: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 3 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) ---
DUE TO (c) ---

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hebephrenic schizophrenia — 43 yrs.

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) ---
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) --- m.
INJURY OCCURED --- While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Sept. 4, 1953, that I last saw the deceased alive on Sept. 4, 1953, and that death occurred at 10:15 A.M. from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) Martin Gross, M. D. ADDRESS Sykesville, Md. DATE SIGNED 9/4/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9-7-53
NAME OF CEMETERY OR CREMATORY New Cathedral
LOCATION (City, town, or county) (State) Balto. Md.
DATE REC'D BY LOCAL REGISTRAR Sept. 4, 1953
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Wm Cook, Inc. 1217 St Paul St.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08936

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hale Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
STREET ADDRESS (If rural give location) Deer Park Road

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) (Last) Whittington

4. DATE OF DEATH: (Month) Sept. 8 (Day) (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Jan. 12, 1890

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore County

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Virgil Whittington

14. MOTHER'S MAIDEN NAME: Tide Wheeler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Albright, Reisterstown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

502.1

Immediate cause (a) Myocarditis Chronic decompensated — Interval Between Onset And Death: 2 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) arteriosclerosis-general — years

DUE TO (c) Chronic Bronchitis — years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-30, to 9-8-, 1953, that I last saw the deceased alive on 9-7-53, 19, and that death occurred at 9 PM, from the causes and on the date stated above.

SIGNATURE James L. Saffell M.D. (Degree or Title) ADDRESS Reisterstown Md DATE SIGNED 9-10-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept. 11, 1953
NAME OF CEMETERY OR CREMATORY: Bosley's Cem.
LOCATION (City, town, or county) (State): Baltimore County

DATE REC'D BY LOCAL REGISTRAR 9-10-53
REGISTRAR'S SIGNATURE Mary B. Eline
24. FUNERAL DIRECTOR ADDRESS: J.F. Eline & Sons, Reisterstown, Md.

L. K. Woodward mort.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP. 14 1959
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08938

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) since 10-13-51
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pennsylvania COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wawa V35-3
STREET ADDRESS (If rural give location) School Sanatorium

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) Riggs (Last) Wood
4. DATE OF DEATH: (Month) Sept. (Day) 7 (Year) 1953

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 4-17-1912
9. AGE last birthday: 41 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel R. Wood
14. MOTHER'S MAIDEN NAME: Hilda Kearney

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

473 X

Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 3 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Tonsillitis — " "

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mental deficiency with psychosis — ca. 40 yrs.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Nov. 15, 1951, to Sept. 7, 1953, that I last saw the deceased alive on Sept. 6, 1953, and that death occurred at 12:10 a.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D (Degree or title) Martin Gross, M.D. ADDRESS Sykesville, Md. DATE SIGNED Sept. 7, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9-9-53
NAME OF CEMETERY OR CREMATORY Loudon Park
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR 9-8-53
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Weer & Haight - Sykesville, Md. ADDRESS Luther H. Haight

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 9 1953
BUREAU V. S.